

Laboratory: Anatomic Pathology (AP)

Electronic Signature

User Manual



Version 5.2

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Department of Veterans Affairs

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Product Development

Revision History

Date	Description (Patch # if applicable)	Project Manager	Technical Writer
August 2014	LR*5.2*422 – Updates for ICD-10 Updated Title page Added Revision History (pp. i-ii) Updated Table of Contents (vii-viii) Note added: VistA AP ICD-10 Remediation Patch LR*5.2*422 replacing "ICD9CM" with "ICD" in various menu options (pp. <u>5</u> , <u>6</u> , <u>7</u> , <u>16</u> , <u>17</u> , <u>20</u> , <u>24</u>) Overall: Ensured all screen captures followed the SSN guidelines specified in <i>Displaying Sensitive Data Guide</i> . Updated ICD9 to ICD (pp. <u>5</u> , <u>6</u> , <u>7</u> , <u>16</u> , <u>17</u> , <u>20</u> , <u>24</u> , <u>27</u> , <u>29</u>) Updated Glossary with ICD-10 definition (p <u>44</u>)	REDACTED	REDACTED
05/2004	Initial document published		

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Preface

This documentation is intended for use in conjunction with the VistA Laboratory Anatomic Pathology (AP) Electronic Signature Patch LR*5.2*259. This documentation explains the new and updated functions made available with the application of the Electronic Signature. It combines information from the patch description and the Installation Guide as well as providing additional explanatory material and generic examples to illustrate the operations of the Electronic Signature.

In brief, the VistA Laboratory AP Electronic Signature patch replaces the manual signature process with an electronic signature and includes improvements in operations, management, and reporting within the VistA Laboratory Anatomic Pathology software application.

This user manual should be used in conjunction with other documentation of the VistA Laboratory software application. This manual shows users how to enter, edit, and display information for Cytopathology, Autopsy Pathology, Surgical Pathology, Electron Microscopy, pre-selected lab test lists, and lists of unverified pathology reports. It also shows how to print reports, path micro/dx modification, cum path data summaries, and pre-selected lab test lists.

Intended Audience

The intended audience for this documentation includes users of the VistA Laboratory Anatomic Pathology software application, Laboratory Application Coordinators, Veterans Health Information Systems and Technology Architecture (VistA) sites' Information Resource Management (IRM), VHA Office of Information (OI) Health Systems Design & Development (HSD&D), and Enterprise VistA Support (EVS).

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Orientation

Special Notations and Conventions

The following symbols and formats are used in this user manual to make it easier to read:

- Menu options are shown in italics, for example: *Data entry for autopsies* option.
- Screen captures, or examples of what the user sees on the computer screen, are shaded.
- Responses typed in by the user are shown as bolded and underlined.
Example: Select SPECIMEN: TOE// **KNEE**
- **<Enter>** is shown in examples when the user can press the Enter or Return key instead of typing in a response. Pressing the Enter key will accept any default value shown to the left of the double slash (/).
Example: All Patients or Single Patient: (A/S/E): SINGLE//**<Enter>**
SINGLE
- Double slash (/) is shown for a default. Defaults are responses provided to speed up your entry process. A default value is the most common responses, the safest responses, or the previous response.
- Question marks. On-line help can be displayed by typing in one, two, or three question marks. One question mark will show a brief explanation. Two question marks will display more information and hidden actions. Three question marks will provide the most detail, which may include a list of possible responses.

References

Following is a list of related VHA HSD&D documentation that can also be found in the VistA Documentation Library (VDL) under the Clinical heading:

- *VistA Laboratory Anatomic Pathology Electronic Signature Installation Guide*
- *VistA Laboratory Anatomic Pathology V. 5.2 User Manual*
- *VistA Laboratory V. 5.2 User Manual*
- *VistA CPRS Text Integration Utility V. 1*
- *VistA CPRS Authorization/Subscription Utility V. 1*

Documentation Website Locations:

This document is available in MS Word (.doc) format and in Portable Document Format (.pdf) at the following VA intranet website locations:

VistA Laboratory Home Page

<http://vista.med.va.gov/ClinicalSpecialties/lab/>

VistA Documentation Library (VDL)

<http://www.va.gov/vdl/>

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Introduction

VistA Laboratory Anatomic Pathology (AP) Electronic Signature (Patch LR*5.2*259) software release implements the new electronic signature functionality within the Autopsy, Cytology, Electron Microscopy, and Surgical Pathology sections for the Autopsy Protocol, Standard Form 515 (also known as SF 515), and supplementary reports. This new functionality can be activated or inactivated at the site's discretion by using the **new** *Turn Electronic Signature On/Off* option. The electronic signature is applied to released autopsy and anatomic reports during the verification or release process.

This patch enhances the process of signing and releasing Anatomic Pathology reports. Previously, the verification/release process for pathology reports involved a yes or no question that date-time stamped the file to indicate the report had been verified or released. A paper copy was then printed and signed by the pathologist by hand.

This patch replaces the manual signature process with an electronic signature. The authorized signer is now prompted to electronically sign the report. The signer can view the report in the VA FileMan browser prior to electronically signing. The electronically signed report is stored in TIU (Text Integration Utility) and includes a signature name and date-time stamp in the text near the bottom of the last page.

Cytotechnologist Granted Authority to Sign Negative GYN Cytology Reports

With the June 2003 release of VHA Handbook 1106.1, *Pathology and Laboratory Medicine Service Procedures*, cytotechnologists have been granted authority to sign out negative GYN reports. A cytotechnologist who is properly set up to sign out anatomic pathology reports is able to sign out and release SF 515 reports for Cytotechnology sections.

VistA Blood Bank Software Version 5.2

VistA Laboratory Package patch LR*5.2*259 contains changes to software controlled by VHA DIRECTIVE 99-053, titled VistA BLOOD BANK SOFTWARE. Changes include:

Changes to the name formatting subroutine in ^LRUA

Changes to the Electron Microscopy sub-file (#63.02) in the LAB DATA file (#63)

Changes to the Surgical Pathology sub-file (#63.08) in the LAB DATA file (#63)

Changes to the Cytopathology sub-file (#63.09) in the LAB DATA file (#63)

The addition of the AP ESIG ON field (#619) to the LABORATORY SITE file (#69.9)

All of the above changes have been reviewed by the VistA Blood Bank Developer and found to have no impact on the VistA BLOOD BANK SOFTWARE control functions.

RISK ANALYSIS: Changes made by patch LR*5.2*259 have no effect on Blood Bank software functionality, therefore RISK is none.

EFFECT ON BLOOD BANK FUNCTIONAL REQUIREMENTS: Patch LR*5.2*259 does not alter or modify any software design safeguards or safety critical elements functions.

POTENTIAL IMPACT ON SITES: This patch contains changes to one routine and two files identified in Veterans Health Administration (VHA) Directive 99-053, group B listing. The changes have no effect on Blood Bank functionality or medical device control functions. There is no adverse potential to sites.

VALIDATION REQUIREMENTS BY OPTION: Because of the nature of the changes made, no specific validation requirements exist as a result of installation of this patch.

Enhancements

VistA Laboratory Anatomic Pathology Electronic Signature software release contains the following enhancements for the Surgical Pathology, Cytology, Electron Microscopy, and Autopsy sections.

1. Turn Electronic Signature On/Off [LRAP ESIG SWITCH] option

This **new** option allows the electronic signature functionality to be activated or deactivated at any time for the Surgical Pathology, Cytology, Electron Microscopy, and Autopsy sections. This new option is located on the Anatomic pathology [LRAP] menu, Supervisor, anat path [LRAPSUPER] menu and requires the LRLIASON security key.

NOTE: Whenever the electronic signature functionality is deactivated the Verify/release reports, anat path [LRAPR] and Supplementary report release anat path [LRAPRS] options use the existing 'YES/NO' prompt. However, when these options are used the released Autopsy protocol, SF515, and Supplementary reports will not be stored in the TIU DOCUMENTS file (#8925) and a signed hard copy will be required.

2. Modify released pathology report [LRAPMRL] option

This **new** option allows editing of electronically and manually signed Autopsy Protocol, SF515, and supplementary reports for Surgical Pathology, Cytology, Electron Microscopy, and Autopsy sections. All electronically and manually signed reports that have been modified and released will display a "MODIFIED" banner when the reports are either displayed or printed. When the electronically and manually signed report diagnosis field is edited a "MODIFIED DIAGNOSIS" banner is displayed. This **new** Modify released pathology report [LRAPMRL] option requires the **new** LRAPMOD security key to be assigned.

3. Autopsy Protocol and Supplementary Reports:

The new electronic signature functionality is available for the Autopsy protocol and supplementary reports when activated. The new functionality prompts for an electronic signature rather than requesting a 'YES/NO' response to the question, "Release Report?"

NOTE: The Electronic signature date and time is NOT displayed in the text of the supplementary reports.

4. AP SF515 and Supplementary Reports

The **new** electronic signature functionality is available in the Surgical Pathology, Cytology, and Electron Microscopy sections for SF515 and supplementary reports. The release process is enhanced to prompt for an electronic signature rather than prompting for a 'YES/NO' response to the question "Release Reports?".

NOTE: Electronically signed supplementary reports will NOT display the electronic signature and date/time stamp in the text of the supplementary report.

5. New Alert:

The **new** electronic signature alert is available when the electronic signature functionality is activated. The new alert prompt will appear in the Verify/release reports, anat path [LRAPR] option immediately after the authorized signer enters an electronic signature. This alert proceeds as follows:

Example: New Electronic Signature Alert

- a.) A yes/no alert prompt will appear.
- b.) If answered yes, the alert will be sent by default to both the physician on file for the accession and the patient's primary care provider (if one is on file.)
- c.) The signer will then be prompted to optionally include any additional names or mail groups as receivers of the alert.
A name is entered as LAST,FIRST and a mail group as G.MAILGROUP.

The text of the alert is as follows:

```
Pathology report signed for SP 02 1 - LABPATIENT, ONE
```

NOTE: The **new** electronic signature alert is designed to operate ONLY within the **VistA** Laboratory software application; however, with the implementation of CPRS GUI V.1.0.22.12, the alerts can be viewed, in a modified format, in the CPRS GUI application's Notifications section of the Patient Selection screen.

Modifications

The VistA Laboratory Anatomic Pathology Electronic Signature software release consists of the following modifications for the Autopsy, Surgical Pathology, Cytology, and Electron Microscopy sections:

Autopsy Section Changes:

1. The following options were modified to REMOVE EDITING of the released Autopsy protocol and supplementary reports:

- Provisional anatomic diagnoses [LRAPAUPAD] option
- Autopsy protocol [LRAPAUDAP] option
- Autopsy protocol & SNOMED coding [LRAPAUDAB] option
- Autopsy protocol & ICD coding [LRAPAUDAA] option
- Final autopsy diagnoses date [LRAPAUFDAD] option
- Autopsy supplementary report [LRAPAUSR] option
- Special studies, autopsy [LRAPAUDAS] option

2. The following autopsy options are modified to ADD CPT coding for the unreleased or released Autopsy protocol report:

- Provisional anatomic diagnoses [LRAPAUPAD]
- Autopsy protocol [LRAPAUDAP] option
- Autopsy protocol & SNOMED coding [LRAPAUDAB] option
- Autopsy protocol & ICD coding [LRAPAUDAA] option

NOTE: VistA AP ICD-10 Remediation Patch LR*5.2*422 replaces "ICD9CM" with "ICD" in the following Menu Option:

- "Autopsy protocol & ICD9CM coding [LRAPAUDAA]" is now "Autopsy protocol & ICD coding [LRAPAUDAA]".

3. Autopsy protocol and supplementary report header and footer formats were **modified** for uniformity.

4. Autopsy protocol and supplementary report headers (i.e., OTHER LIMITATIONS) has been modified to eliminate missing digits from the accession number.

5. Print routines are modified to first check for storage of the reports in the TIU DOCUMENT file (#8925) and if not there, to extract the data from the LAB DATA file (#63) in order to print released Autopsy protocol and supplementary reports.

Surgical Pathology, Cytology, and Electron Microscopy Sections Changes:

1. The 'DATE REPORT COMPLETED' prompt is REMOVED from released SF515 reports.
2. SF515 and supplementary report headers and footers format were **modified** for uniformity across the Surgical Pathology, Cytology, and Electron Microscopy sections.
3. SF515 and supplementary single and multiple report functionality were **modified** to display via the VA FileMan browser.
4. The Physician Name field located on the SF515 and supplementary reports is **modified** to conform to the Kernel's Application Program Interface (API) format design.
5. SF515 and supplementary reports are **modified** to eliminate printing of blank pages at the beginning and ending of the reports.
6. Released AP SF515 and supplementary report for inpatients were **modified** to eliminate truncation of the footers.
7. Print routines are modified to first check for storage of the reports in the TIU DOCUMENT file (#8925), and if not there, to extract the data from the LAB DATA file (#63), in order to print released SF515 and supplementary reports.
8. The following AP options are **modified** to REMOVE EDITING of the released SF515 and supplementary reports:
 - Clinical Hx/Gross Description/FS [LRAPDGD] option
 - FS/Gross/Micro/Dx [LRAPDGM] option
 - FS/Gross/Micro/Dx/SNOMED Coding [LRAPDGS] option
 - FS/Gross/Micro/Dx/ICD Coding [LRAPDGI] option
 - Supplementary Report, Anat Path [LRAPDSR] option
 - Spec Studies-EM;Immuno;Consult;Pic, Anat Path [LRAPDSS] option
9. The following AP options are **modified** to ADD CPT coding for unreleased or released SF515 and supplementary reports:
 - FS/Gross/Micro/Dx [LRAPDGM] option
 - FS/Gross/Micro/Dx/SNOMED Coding [LRAPDGS] option
 - FS/Gross/Micro/Dx/ICD Coding [LRAPDGI] option
 - Verify/release reports, anat path [LRAPR] option

NOTE: VistA AP ICD-10 Remediation Patch LR*5.2*422 replaces "ICD9CM" with "ICD" in the following Menu Option:

- FS/Gross/Micro/Dx/ICD9CM Coding [LRAPDGI]" is now "FS/Gross/Micro/Dx/ICD Coding [LRAPDGI]".

10. The accession functionality for released supplementary reports has been **modified** to provide one of three possible responses when an authorized user attempts to release a supplementary report:

- 1) No supplementary reports exist for the accession
- 2) All supplementary reports for the accession have been released
- 3) Will default to the first unreleased supplementary report found for the accession.

11. The released SF515 report functionality is **modified** to NO longer display SNOMED codes. This prevents misinterpretation of the diagnosis from viewers outside of the Lab Medicine section. SNOMED codes can be displayed and printed using the following options:

- Verify/release reports, anat path [LRAPR] option.
- Print all reports on queue [LRAP PRINT ALL ON QUEUE] option.
- Print single report only [LRAP PRINT SINGLE] option.
- Print final path reports by accession # [LRAPFICH] option.

NOTE: SNOMED code may be entered regardless of the unreleased or released SF515 report status using the FS/Gross/Micro/Dx/SNOMED Coding [LRAPDGS] or SNOMED coding, anat path [LRAPX] options.

12. The released SF515 report functionality was modified to NO longer display ICD diagnosis codes on the reports. The FS/Gross/Micro/Dx/ICD Coding [LRAPDGI] option is used for ICD coding for unreleased or released SF515 reports. When this option is used ICD codes are not stored in the TIU DOCUMENT file (#8925) and will not be displayed on the final office copy report.

NOTE: VistA AP ICD-10 Remediation Patch LR*5.2*422 replaces "ICD9CM" with "ICD" in the following Menu Options:

- FS/Gross/Micro/Dx/ICD9CM Coding [LRAPDGI]" is now "FS/Gross/Micro/Dx/ICD Coding [LRAPDGI]".

13. The released SF515 report functionality was **modified** to display the PRIMARY CARE PROVIDER in place of the SURGEON/PHYSICIAN in the footer of the released SF515 report. The released SF515 report displays the following names:

- 1) SUBMITTING PHYSICIAN
- 2) SURGEON/PHYSICIAN
- 3) PRIMARY CARE PROVIDER (newly added to the footer)
- 4) RESPONSIBLE PATHOLOGIST or CYTOTECHNOLOGIST.

14. The released SF515 report functionality is **modified** to check for missing pathologist or cytotechnologist names and reports completion dates. Whenever data is missing from reports, the electronic signer is notified that the release process is terminated. The release process verifies that the SF515 report pertinent data is entered before the reports are released.

15. The supplementary report functionality is **modified** to NO longer allow deletion of a supplementary report. Upon editing of a supplementary report the caption is changed from: “MODIFIED” to ***SUPPLEMENTARY REPORT HAS BEEN ADDED/MODIFIED*** (Added/last modified: AUG 31, 2001@14:54 typed by LABPATIENT, ONE). The part of the caption within parenthesis will display the date/time, name of the person who modified the supplementary report and the words “typed by”. When the supplementary report is released, the caption within parenthesis will display the date/time, name of the person who released the supplementary report, and the words “signed by”.

NOTE: Supplementary reports can no longer be deleted, but the text of the report can be deleted. The date/time stamp function of the report remains as a security enhancement of the software.

16. The *VistA* Laboratory software was **modified** to correct the released reports added/modified report date/time stamp audit trail information displayed via the *VistA* Computer Patient Record System (CPRS) software application.

Use of the Software

This AP Electronic Signature software release contains the following functionality for Surgical Pathology, Cytology, Electron Microscopy, and Autopsy sections. This section of the user manual describes the enhancements and modifications functionality operationally, in menu option order and screen captures examples.

Required Security Keys

Security keys can be used to restrict a user's access to specific areas. The following security keys **must** be assigned to authorized users requiring access to the **new** Laboratory AP electronic signature functionality:

Security Key	Access
LRLAB security key:	Allows access to the main Laboratory [LRMENU] menu.
LRANAT security key:	Allows access to the main Anatomic Pathology [LRAP] menu where the new <i>Turn Electronic Signature On/Off</i> [LRAP ESIG SWITCH] and <i>Modify released pathology report</i> [LRAPMRL] options reside.
LRAPSUPER security key:	Gives an authorized user access to the Supervisor, anat path [LRAPSUPER] submenu where the new <i>Turn Electronic Signature On/Off</i> [LRAP ESIG SWITCH] option is located.
LRLIASON security key:	Gives an authorized user access to the new <i>Turn Electronic Signature On/Off</i> [LRAP ESIG SWITCH] option.
LRAPMOD security key: (NEW)	This new security key gives an authorized user access to the new <i>Modify released pathology report</i> [LRAPMRL] option.
LRVERIFY security key:	Gives an authorized user access to anatomic pathology setup tasks and gives authorization to electronically sign Autopsy Protocol, SF 515, and supplementary released reports.
PROVIDER security key:	Gives an authorized user access to anatomic pathology setup tasks and gives authorization to electronically sign Autopsy Protocol, SF 515, and supplementary released reports. It also enables the authorized signer to be listed as the Provider of the pathology case in the TIU report document. Without this key, the authorized signer is not allowed to sign or release a report.

Anatomic Pathology [LRAP] Menu New Option

This section describes changes to the Anatomic Pathology [LRAP] menu and options as a result of the AP Electronic Signature patch LR*5.2*259 release. The main options included in the Anatomic Pathology [LRAP] menu are listed below. Each option contains submenus. To the left of the option name is the shortcut synonym you can enter to select the option.

Example: Anatomic Pathology [LRAP] Menu

<i>Anatomic Pathology [LRAP] Menu</i>	
D	<i>Data entry, anat path ...</i>
E	<i>Edit/modify data, anat path ...</i>
I	<i>Inquiries, anat path ...</i>
L	<i>Log-in menu, anat path ...</i>
P	<i>Print, anat path ...</i>
R	<i>SNOMED field references ...</i>
S	<i>Supervisor, anat path ...</i>
V	<i>Verify/release menu, anat path ...</i>
C	<i>Clinician options, anat path ...</i>
W	<i>Workload, anat path ...</i>

How to ACTIVATE the new AP Electronic Signature Feature

The **new** *Turn Electronic Signature On/Off* [LRAP ESIG SWITCH] option is a toggle switch. It turns the **new** AP electronic signature feature ON or OFF. This option requires the LRLIASON security key.

Example: *Turn Electronic Signature On/Off* [LRAP ESIG SWITCH] option

NOTE: Once this option is turned on, it should remain on. It should be turned off only if the software at the site is experiencing problems caused by turning on the option. One possible problem that can occur is that the links between original and modified reports will be lost if the original was released with the switch ON and then modified after the switch is turned OFF.

```
Select Anatomic pathology Option: S Supervisor, anat path<RET>

DD Delete anat path descriptions by date
ED Enter/edit lab description file
ER Edit pathology parameters
ES Enter/edit items in a SNOMED field ...
IR Incomplete reports, anat path
MR Print path modifications
TC Anatomic pathology topography counts
DS Delete free text specimen entries
QA AP quality assurance ...
AF AFIP registries ...
SW Turn Electronic Signature On/Off
  Edit referral patient file

SW Turn Electronic Signature On/Off

AP electronic signature is inactive.

Do you wish to activate electronic signature for AP? NO// YES...Done
```

Editing Electronically and Manually Signed AP Reports

New *Modify released pathology report [LRAPMRL]* option:

The **new** *Modify released pathology report [LRAPMRL]* option allows editing of electronically and manually signed Supplementary, SF 515 and Autopsy Protocol reports for all Anatomic Pathology sections (i.e., surgical pathology, cytology, electron microscopy, and autopsy). All released AP reports, either signed electronically or manually, that is modified and released, will display a “Modified” banner when the reports are viewed or printed. This **new** option is a sub option of the *Edit/modify data, anat path [LRAPE]* option included on the main Anatomic Pathology [LRAP] menu and requires the **new** LRAPMOD security key

Edit Report and Edit Diagnosis Selections

This **new** option offers **two** edit selections, Edit Report and Edit Diagnosis:

- The Edit Report selection allows editing of all editable fields on the report, except for diagnosis (as shown in Example 1).
- The Edit Diagnosis selection allows editing of only the diagnosis (as shown in Example 2). When the signed report diagnosis field is edited, a “Modified Diagnosis” banner is displayed in place of the modified banner.

NOTE: If a site turns off the diagnosis entry prompt for a particular AP section, the edit diagnosis selection does not display. In this case, the user automatically moves into the edit report selection.

Example 1: Modify released pathology report [LRAPMRL] option

The 'Edit Report' selection allows editing of all updateable fields on the report, EXCEPT for the DIAGNOSIS field.

```
Select Anatomic pathology Option: E Edit/modify data, anat path<Enter>

LI  Edit log-in & clinical hx, anat path
MM  Modify released pathology report
SC  Edit anat path comments

Select Edit/modify data, anat path Option: MM Modify released pathology
report<Enter>
    Modify Released Pathology Reports

        NOTICE

        This option allows modification of a verified/released pathology
report. Continuing with this option will unrelease the report and flag
the report as modified even if the data is unchanged. It will also be
queued to the final report queue so that it may be verified/released
again.
Do you wish to continue? NO//YES<Enter>

    Select one of the following:
    1  Edit Report
    2  Edit Diagnosis

Enter selection: 1// 1 Edit Report<Enter>

Select ANATOMIC PATHOLOGY SECTION: SURGICAL PATHOLOGY<Enter>

    SURGICAL PATHOLOGY (NSP)

Edit etiology, function, procedure & disease? NO//<Enter>

Data entry for 2002 ? YES//<Enter>
Select Accession Number/Pt name: 8 for 2002<Enter>

LABPATIENT, TWO      000-00-0002  DOB: Apr 10, 1950
Collection Date: Sep 06, 2002
Acc #: NSP 02 8
Tissue Specimen(s):
    TOE
Test(s): H & E STAIN
    PARAFFIN BLOCK
    PARAFFIN BLOCK, ADDITIONAL CUT
    SURGICAL PATH REPORTING
    SURGICAL PATHOLOGY LOG-IN
PATIENT LOCATION: 4N// 3ED<Enter>
SURGEON/PHYSICIAN: LABPROVIDER, ONE// <Enter>
SPECIMEN SUBMITTED BY: LP// LABUSER, THREE<Enter>
Select SPECIMEN: TOE// KNEE<Enter>
```

```
Select SPECIMEN: <Enter>
BRIEF CLINICAL HISTORY: <Enter>
TEST STATEMENT FOR CLINICAL HISTORY.
CHECK FOR GANGRENE.
  Edit? NO//<Enter>
PREOPERATIVE DIAGNOSIS: <Enter>
TESTING STATEMENT FOR CLINICAL HISTORY SECTION.

  Edit? NO//YES<Enter>

TESTING STATEMENT FOR CLINICAL HISTORY SECTION.

ADDITIONAL UPDATE TO RELEASED REPORT.

[End of file]

OPERATIVE FINDINGS: <Enter>
  No existing text
  Edit? NO//<Enter>
POSTOPERATIVE DIAGNOSIS: <Enter>
  No existing text
  Edit? NO//<Enter>
DATE/TIME SPECIMEN RECEIVED: SEP 6,2003@15:30//<Enter>
PATHOLOGIST: LABPROVIDER, THREE//<Enter>
RESIDENT PATHOLOGIST:<Enter>
Select COMMENT: TESTING//<Enter>
Select DELAYED REPORT COMMENT:<Enter>
Select ORGAN/TISSUE: TOE//<Enter>
  ORGAN/TISSUE: TOE//<Enter>
  Select MORPHOLOGY: CELL CONTENT ALTERATION//<Enter>
  MORPHOLOGY: CELL CONTENT ALTERATION//<Enter>
  Select MORPHOLOGY:<Enter>
  Select SPECIAL STUDIES: <Enter>
Select ORGAN/TISSUE: <Enter>
Select ICD DIAGNOSIS: <Enter>
DATE REPORT COMPLETED: SEP 6,2002// T (NOV 05, 2002)<Enter>
Edit GROSS DESCRIPTION? NO//<Enter>
Edit MICROSCOPIC DESCRIPTION? NO// <Enter>
Edit FROZEN SECTION? NO//<Enter>
Edit SUPPLEMENTARY REPORTS? NO//<Enter>
Enter CPT CODING? NO//<Enter>
```

Example 2: Edit a Diagnosis

The 'Edit Diagnosis' selection allows editing of ONLY the diagnosis field.

```

Select Anatomic pathology Option: E Edit/modify data, anat path<Enter>

LI  Edit log-in & clinical hx, anat path
MM  Modify released pathology report
SC  Edit anat path comments

Select Edit/modify data, anat path Option: MM Modify released pathology
report<Enter>

    Modify Released Pathology Report

        NOTICE

        This option allows modification of a verified/released pathology
report. Continuing with this option will unrelease the report and flag
the report as modified even if the data is unchanged. It will also be
queued to the final report queue so that it may be verified/released
again.

Do you wish to continue? NO//YES<Enter>

    Select one of the following:

    1  Edit Report
    2  Edit Diagnosis

Enter selection: 1// 2 Edit Diagnosis<Enter>

Select ANATOMIC PATHOLOGY SECTION: surGICAL PATHOLOGY<Enter>

    SURGICAL PATHOLOGY (NSP)

Data entry for 2002 ? YES//YES<Enter>

Select Accession Number/Pt name: 8 for 2002<Enter>

LABPATIENT, THREE      000-00-0003   DOB: Apr 10, 1950
Collection Date: Sep 06, 2002
Acc #: NSP 02 8
Tissue Specimen(s):
    TOE
Test(s): H & E STAIN
    PARAFFIN BLOCK
    PARAFFIN BLOCK, ADDITIONAL CUT
    SURGICAL PATH REPORTING
    SURGICAL PATHOLOGY LOG-IN

SURGICAL PATH DIAGNOSIS: <Enter>
FINAL DIAGNOSIS TEXT ENTRY.
UPDATE ADDED TO DIAGNOSIS TO TEST MODIFIED REPORT OPTION

```

```

FOR E SIGNATURE PATCH.

Edit? NO// YES<Enter>

FINAL DIAGNOSIS TEXT ENTRY.

ADDITIONAL UPDATE TO RELEASED REPORT

[End of file]

```

Modified Anatomic Pathology [LRAP] Menu Options

Anatomic Pathology menu options that have been modified as part of the electronic signature functionality are described below. The options are listed and discussed in menu option order. Top-level menu options that have been modified are in bold as follows:

- D** *Data entry, anat path ...*
- E *Edit/modify data, anat path ...*
- I *Inquiries, anat path ...*
- L** *Log-in menu, anat path ...*
- P** *Print, anat path ...*
- R *SNOMED field references ...*
- S *Supervisor, anat path ...*
- V** *Verify/release menu, anat path ...*
- C *Clinician options, anat path ...*
- W *Workload, anat path ...*

Data entry, anat path [LRAPD] Menu

The *Data entry, anat path ...* menu contains sub-options, listed below. To the left is the shortcut synonym you can enter to select the option. The sub-options that have been modified are in bold.

- AU** *Data entry for autopsies...*
- BS** *Blocks, Stains, Procedures, anat path*
- CO** *Coding, anat path...*
- GD** *Clinical Hx/Gross Description/FS*
- GM** *FS/Gross/Micro/Dx*
- GS** *FS/Gross/Micro/Dx/SNOMED Coding*
- GI** *FS/Gross/Micro/Dx/ICD Coding*
- OR *Enter old anat path records*
- SR** *Supplementary Report, Anat Path*
- SS** *Spec Studies-EM; Immuno; Consult; Pic, Anat Path*

NOTE: VistA AP ICD-10 Remediation Patch LR*5.2*422 replaces "ICD9CM" with "ICD" in the following Menu Option:

- FS/Gross/Micro/Dx/ICD9CM Coding [LRAPDGI]" is now "FS/Gross/Micro/Dx/ICD Coding [LRAPDGI]".

Data entry for autopsies [LRAPAUDA]

The *Data entry, for autopsies*, [LRAPAUDA] submenu contains the following options. To the left is the shortcut synonym you can enter to select the option. The sub-options that have been modified in this patch are in bold.

PD *Provisional anatomic diagnosis*
AP *Autopsy protocol*
AS *Autopsy protocol & SNOMED coding*
AI *Autopsy protocol & ICD coding*
AF *Final autopsy diagnoses date*
SR *Autopsy supplementary report*
SS *Special studies, autopsy*

NOTE: VistA AP ICD-10 Remediation Patch LR*5.2*422 replaces "ICD9CM" with "ICD" in the following Menu Option:

- "Autopsy protocol & ICD9CM coding [LRAPAUDAA]" is now "Autopsy protocol & ICD coding [LRAPAUDAA]".

Provisional anatomic diagnoses [LRAPAUPAD] option

This option is modified to add CPT coding for released and unreleased Autopsy Protocol reports and to remove editing of signed (electronically or manually) released Autopsy Protocol reports. It allows entry of preliminary autopsy diagnoses for all unreleased Autopsy Protocol Reports.

Example: When a released Autopsy Protocol report is selected for editing, the following message is displayed:

```
Report has been verified. Only CPT coding permitted.
```

```
Enter CPT coding? NO// <ENTER>
```

Example: Computer dialog if the user responded “Yes” to the “Enter CPT Coding” prompt.

```
Report has been verified. Only CPT coding permitted.

Enter CPT coding? NO//YES

Releasing Pathologist: LABPROVIDER, FOUR//LP SENIOR PATHOLOGIST<Enter>
Would you like to see PCE CPT Information? No//YES

CPT: 88300          PATIENT NAME: LABPATIENT, ONE
VISIT: APR 03, 2003@12:0 PROVIDER NARRATIVE: SURGICAL PATH, GROSS
QUANTITY: 1       ENCOUNTER PROVIDER: LABPROVIDER1, THREE

CPT: 88302          PATIENT NAME: LABPATIENT, FOUR
VISIT: APR 03, 2003@12:01
PROVIDER NARRATIVE: TISSUE EXAM BY PATHOLOGIST
QUANTITY: 1
CPT MODIFIER: 59
ENCOUNTER PROVIDER: LABPROVIDER, FIVE

Select CPT codes:4
LABPATIENT, ONE    000-00-3478  DOB: Apr 04, 1948
Collection Date: Apr 03, 2003
Acc #: NAU 03 11   Loc: 3 EAST
PCE ENC # 393;394;394;
Specimen:
Test(s);
Selected CPT Codes

(1) 88305 LEVEL IV - SURGICAL PATHOLOGY, GROSS AND MICROSCOP
Surgical Pathology Level IV {88555.0000}

Is this correct ? Yes//<Enter> YES
Sending PCE Workload
Visit # 394
Storing LMIP Workload
```

Autopsy protocol [LRAPAUDAP]

This option is modified to add CPT coding for released and unreleased Autopsy Protocol reports and to remove editing of signed (electronically or manually) released Autopsy Protocol reports. When a released Autopsy Protocol report is selected for editing, the following message is displayed. If you respond “Yes” to the “Enter CPT coding” prompt, you will be asked to enter CPT codes for the released Autopsy Protocol report.

Example: If you respond “Yes” to the “Enter CPT coding” prompt.

```
Report has been verified. Only CPT coding permitted.  
Enter CPT coding? NO//<Enter>
```

Autopsy protocol & SNOMED coding [LRAPAUDAB]

This option is modified to add CPT coding for released and unreleased Autopsy Protocol reports and to remove editing of signed (electronically or manually) released Autopsy Protocol reports. Existing SNOMED coding functionality is allowed for released and unreleased Autopsy Protocol reports. When a released Autopsy Protocol report is selected, the following message displays. If you respond “Yes” to the “Enter SNOMED coding”, you will be asked to enter SNOMED and CPT codes for the released Autopsy Protocol report.

Example: If you respond “Yes” to the “Enter SNOMED coding.

```
Report has been verified. Only CPT and SNOMED coding permitted.  
Enter SNOMED coding? NO//<Enter>  
Enter CPT coding? NO//<Enter>
```

Autopsy protocol & ICD coding [LRAPAUDAA] option

NOTE: VistA AP ICD-10 Remediation Patch LR*5.2*422 replaces "ICD9CM" with "ICD" in the following Menu Option:

- "Autopsy protocol & ICD9CM coding [LRAPAUDAA]" is now "Autopsy protocol & ICD coding [LRAPAUDAA]".

This option is modified to add CPT coding for released and unreleased Autopsy Protocol reports and to remove editing of signed (electronically or manually) released Autopsy Protocol reports.

Example: When a released Autopsy Protocol report is selected, the following message is displayed.

```
Report has been verified. Only CPT coding permitted.  
Enter CPT coding? NO//<Enter>
```

Final autopsy diagnoses date [LRAPAUFD] option

This option is modified to remove editing of signed (electronically or manually) released Autopsy Protocol reports.

Example: When a released Autopsy Protocol report is selected, the following message is displayed.

```
Report verified. Cannot edit with this option!
```

Autopsy supplementary report [LRAPASUR] option

This option is modified to remove editing of electronically or manually signed released Autopsy Supplementary reports.

Example: When a released Autopsy Supplementary report is selected, the following message is displayed.

```
Report verified. Cannot edit with this option!
```

Special studies, autopsy [LRAPAUDAS] option

This option is modified to remove editing of signed (electronically or manually) released Autopsy Protocol reports. When a released Autopsy Protocol report is selected, the following message is displayed.

```
Report verified. Cannot edit with this option!
```

Coding, anat path Submenu:

SNOMED coding, anat path [LRAPX] option

This option is modified to remove the “DATE REPORT COMPLETED” prompt when a released Autopsy Protocol or SF 515 report is edited. Data entry and editing is allowed for both released (see Example 1) and unreleased (see Example 2) SF 515 and Autopsy Protocol reports. This option also allows entry of SNOMED and some non-SNOMED coding if the SF 515 and Autopsy Protocol reports are unreleased.

Example1: When these reports are released, only SNOMED coding is permitted.

```
Select Accession Number/Pt name: 75 for 2003
LABPATIENT, FIVE ID: 000-00-0005
Specimen(s) :
TOE

Select ORGAN/TISSUE: UPPER RESPIRATORY FLUIDS AND SPACES//<Enter>
ORGAN/TISSUE: UPPER RESPIRATORY FLUIDS AND SPACES//<Enter>
Select MORPHOLOGY: ABSCESS, DRAINING// <Enter>
MORPHOLOGY: ABSCESS, DRAINING// <Enter>
```

Example 2: Editing allowed for an un-released report

Notice the only difference from the previous example is the inclusion of the Date Report Completed prompt:

```
Select Accession Number/Pt name: 77 for 2003
LABPATIENT, SIX ID: 000-00-0006
Specimen(s) :
TOE

DATE REPORT COMPLETED: JUN 13,2003//<Enter>

Select ORGAN/TISSUE: ABDOMEN// <Enter>
ORGAN/TISSUE: ABDOMEN// <Enter>
Select MORPHOLOGY: ABSCESS, DRAINING// <Enter>
MORPHOLOGY: ABSCESS, DRAINING// <Enter>
```

Clinical Hx/Gross Description/FS [LRAPDGD] option

This option is modified to remove editing of released SF 515 reports. It allows entry of anatomic pathology specimen gross description and clinical history for unreleased SF 515 reports.

Example: When a released SF 515 report is selected, the following message is displayed.

```
Report verified. Cannot edit with this option.
```

FS/Gross/Micro/Dx [LRAPDGM] option

This option is modified to add CPT coding for released and unreleased SF 515 reports, and to remove editing of signed (electronically or manually) released SF 515 reports. When a released SF 515 report is selected, the following message is displayed.

Example: Included in this example is a series of prompts presented to the user if they answer “Yes” to the “Enter CPT Coding” prompt for the released SF 515 report.

```

Select Data entry, anat path Option: GM FS/Gross/Micro/Dx
Select ANATOMIC PATHOLOGY SECTION: SURGICAL PATHOLOGY

    SURGICAL PATHOLOGY (NSP)

Data entry for 2002 ? YES// <Enter> (YES)

Select Accession Number/Pt name: 75 for 2003

LABPATIENT, SEVEN ID: 000-00-0007
Specimen(s):
TOE
Report has been verified. Only CPT coding permitted.

Enter CPT coding? NO// YES

Releasing Pathologist: LABPROVIDER, SIX// <Enter> LPS SR PATHOLOGIST
Would you like to see PCE CPT Information? No// YES

CPT: 88302      PATIENT NAME: LABPATIENT, SEVEN
VISIT: JUN 12, 2003@12:01
PROVIDER NARRATIVE: TISSUE EXAM BY PATHOLOGIST
QUANTITY: 1
CPT MODIFIER: 59
ENCOUNTER PROVIDER: LABPROVIDER SEVEN

CPT: 88304      PATIENT NAME: LABPATIENT, ONE VISIT: JUN 12, 2003@12:01
PROVIDER NARRATIVE: TISSUE EXAM BY PATHOLOGIST
QUANTITY: 1
CPT MODIFIER: 59
ENCOUNTER PROVIDER: LABPROVIDER, EIGHT

Select CPT codes: 88305
LABPATIENT, SEVEN      000-00-0007  DOB: May 05, 1925
Collection Date: Jun 12, 2003
Acc #: NSP 03 75      Loc: 3E
PCE ENC # 405;405;
Specimen:
Tissue Specimens:
TOE
Test(s); SURGICAL PATH REPORTING/ SURGICAL PATHOLOGY LOG-IN/
Selected CPT Codes

(1) 88305 LEVEL IV - SURGICAL PATHOLOGY, GROSS AND MICROSCOP
Surgical Pathology Level IV {88555.0000}
Is this correct ? Yes// <Enter> YES

    Sending PCE Workload
    Visit # 405
    Storing LMIP Workload

```

FS/Gross/Micro/Dx/SNOMED Coding [LRAPDGS]

This option is modified to add CPT coding for released and unreleased SF 515 reports and to remove editing of signed (electronically or manually) released SF 515 reports. It allows review of gross specimen and frozen section descriptions and entry of microscopic description and diagnoses for unreleased SF 515 reports. SNOMED coding is allowed for released and unreleased SF 515 reports.

Example: When a released SF 515 report is selected, the following message is displayed:

```
Report has been verified. Only CPT and SNOMED coding permitted.  
Enter SNOMED coding? NO// <Enter>  
Enter CPT coding? NO//<Enter>
```

FS/Gross/Micro/Dx/ICD Coding [LRAPDGI] option

This option is modified to add CPT coding for signed (electronically or manually) released and unreleased SF 515 reports and to remove editing of released SF 515 reports. It allows gross specimen and frozen description reviews, microscopic and diagnosis descriptions entries, and ICD CM coding for unreleased SF 515 reports.

NOTE: VistA AP ICD-10 Remediation Patch LR*5.2*422 replaces "ICD9CM" with "ICD" in the following Menu Option:

- FS/Gross/Micro/Dx/ICD9CM Coding [LRAPDGI]" is now "FS/Gross/Micro/Dx/ICD Coding [LRAPDGI]".

Example: When a released SF 515 report is selected the following message is displayed. If you respond “Yes” to the “Enter CPT Coding” prompt, you will be asked to enter CPT codes for the accession

```
Report has been verified. Only CPT coding permitted.  
Enter CPT coding? NO//<Enter>
```

Supplementary Report, Anat Path [LRAPDSR] option

This option is modified to remove editing of released supplementary reports and to remove deletion of supplementary reports from the Cytology, Electron Microscopy, and Surgical Pathology sections. The text of the supplementary report can be deleted, however the date and time that the supplementary report was initiated is not deleted. This option is also used for adding supplementary reports to unreleased SF 515 reports.

Example: When a released SF 515 report is selected the following message is displayed

Report verified. Cannot edit with this option

Spec Studies-EM;Immuno;Consult;Pic, Anat Path [LRAPDSS]

This option is modified to remove editing of released SF 515 reports.

Example: When a released SF 515 report is selected, the following message is displayed.

Report verified. Cannot edit with this option

Log-in menu, anat path [LRAPL] Menu

The *Log-in, anat path ...* menu contains sub-options, listed below. To the left is the shortcut synonym you can enter to select the option. The sub-option that has been modified is in bold.

- LI** *Log-in, anat path*
- DA Delete accession #, anat path
- PB Print log book
- HW Histopathology Worksheet

NOTE: Modifications to the following log-in options are effective for the Cytology, Electron Microscopy, and Surgical Pathology sections.

Log-in, anat path [LRAPLG]

This option is modified to replace the default value for the “SPECIMEN SUBMITTED BY” prompt from the surgeon or physician’s name to the primary care provider’s name.

If no primary care provider is on file for the patient, the default value for the “SPECIMEN SUBMITTED BY” prompt is blank. The “SPECIMEN SUBMITTED BY” prompt allows free-text entry of 30 alpha and/or numeric characters.

Cytopathology Section

For only the cytopathology accession section, the “PATHOLOGIST” prompt is now changed to “PATHOLOGIST/CYTOTECHNOLOGIST.” Cytotechnologists who have been properly set up to sign out Anatomic Pathology reports are able to sign out SF 515 reports for cytopathology sections.

Example: Assign Provider

```
Select Log-in menu, anat path Option: LI Log-in, anat path
Select ANATOMIC PATHOLOGY SECTION: CYTOPATHOLOGY Log-In for 2003 ?
YES//<Enter>
(YES)
Select Patient Name: Labpatient, Eight LABPATIENT, EIGHT 5-5-55
000000000 NO MILITARY RETIREE
LABPATIENT ID: 000-00-0008
AGE: 48 DATE OF BIRTH: MARCH 9,1999
PATIENT LOCATION: 3N// <Enter> 3 NORTH
Assign CYTOPATHOLOGY (NCY) accession #: 88 ? YES// <Enter> (YES)
Date/time Specimen taken: TODAY// <Enter> (JUL 01, 2003)
PHYSICIAN: LABPROVIDER, THREE LABPROVIDER, THREE LPT
SPECIMEN SUBMITTED BY: LABUSER, ONE
Select SPECIMEN: PAP
WORKLOAD PROFILE: PAP// <Enter> SMEAR PAP
Select SPECIMEN: <Enter>
DATE/TIME SPECIMEN RECEIVED: NOW// <Enter> (JUL 09, 2003@08:50)
PATHOLOGIST/CYTOTECHNOLOGIST: LABPROVIDER, NINE LABPROVIDER, NINE SPD
```

Print, anat path [LRAPP] Menu

The *Print, anat path ...* menu contains sub-options, listed below. To the left is the shortcut synonym you can enter to select the option. The sub-options that have been modified are in bold.

- PQ** *Print all reports on queue*
- DQ *Delete report print queue*
- LQ *List pathology reports in print queue*
- PS** *Print single report only*
- AD *Add patient(s) to report print queue*
- AU *Autopsy administrative reports*
- AR *Anat path accession reports*
- CS *Cum path data summaries*
- LA *Anatomic pathology labels*
- LT *Edit/print/display pre-selected lab tests*
- PB *Print log book*
- PA *Print final path reports by accession #*

NOTE: Modifications to the following options are effective for the Autopsy, Cytology, Electron Microscopy, and Surgical Pathology sections.

Print all reports on queue [LRAP PRINT ALL ON QUEUE] option

The *Print all reports on queue* option is used to print:

1. Preliminary reports listing the clinical history and gross description for review for patients on the cumulative report print queue or
2. Final reports for patients and completed autopsy reports.

The *Print all reports on queue* option is modified as follows:

1. In compliance with the new Kernel API \$\$NAMEFMT^XLFNAME format, the provider name has been reformatted on the Autopsy Protocol and SF 515. Please note that the provider's name must be set up correctly in the NEW PERSON file (#200) for the API to properly format the provider's name. For more information, please review the Kernel API documentation released with patch XU*8.0*134.
2. The ICD diagnosis codes are removed from the Autopsy Protocol and SF 515 reports.
3. The SNOMED codes are removed from the Autopsy Protocol and SF 515 reports.

4. A new page, called Final Office Copy, has been added to the Autopsy Protocol and SF 515 reports for printing SNOMED codes entries. The following example shows the new Final Office Copy prompt that appears when #2 Final reports is selected, and the resulting page that prints the SNOMED Codes when this prompt is answered "Yes":

```
Select Print, anat path Option: PQ Print all reports on queue
Select ANATOMIC PATHOLOGY SECTION: CYTOPATHOLOGY
  1. Preliminary reports
  2. Final reports
Select 1 or 2 : 2

Is this a final office copy? NO// YES
```

Example: The resulting SNOMED Code page:

```
CYTOPATHOLOGY  SNOMED CODE LISTING  Acc: NCY 03 1  Pg: 1
Patient: LABPATIENT, NINE      Physician: LABPROVIDER, TEN
ID: 000-00-0009  Sex: F        DOB: 05/02/1952  Age: 51
-----
Tissue Specimen(s):
  PAP

T-42500: ABDOMINAL AORTA
M-41770: ABSCESS, DRAINING
T-46400: CELIAC ARTERY
M-69610: CELL MITOTIC ACTIVITY, INCREASED

      (End of Report)
```

Print single report only [LRAP PRINT SINGLE]

The *Print single report only* option prints pathology accessions in Cytopath report for electron microscopy, autopsy, or surgical pathology for cumulative reports for micro exams. This option is modified as follows:

1. In compliance with the new Kernel API \$\$NAMEFMT^XLFNAME format, the provider name has been reformatted on the Autopsy Protocol and SF 515. Please note that the provider's name must be set up correctly in the NEW PERSON file (#200) for the API to properly format the provider's name. For more information, please review the Kernel API documentation released with patch XU*8.0*134.
2. The ICD diagnosis codes are removed from the Autopsy Protocol and SF 515 reports.
3. The SNOMED codes are removed from the Autopsy Protocol and SF 515 reports.
4. A new page, called Final Office Copy, has been added to the Autopsy Protocol and SF 515 reports for printing SNOMED codes entries. See the previous example for an illustration of the new Final Office Copy prompt and resulting SNOMED Code page.

Print final path reports by accession # [LRAPFICH]

The *Print final path reports by accession #* option prints pathology reports for cytopathology, electron microscopy, autopsy, or surgical pathology by accession number or for a range of accession numbers. After the user enters the accession section, he or she is prompted "Is this a final office copy?" If the answer is yes, the resulting page includes the SNOMED codes. See the previous example in section 4.3.1 for an illustration of the new Final Office Copy prompt and resulting SNOMED Code page.

Verify/release menu, anat path [LRAPVR] Menu

The *Verify/release menu, anat path ...* menu contains sub-options, listed below. To the left is the shortcut synonym you can enter to select the option.

The Electronic Signature patch has modified each of these sub-options. The following modifications are effective for all Anatomic Pathology sections.

- RR** *Verify/release reports, anat path*
- RS** *Supplementary report release, anat path*
- LU** *List of unverified pathology reports*

Verify/release reports, anat path [LRAPR] option

The *Verify/release reports, anat path* option is used to verify and release electronically or manually signed Autopsy Protocol and SF 515 reports to medical personnel on the wards. This option still requires the LRVERIFY security key.

Referral Patient Reports

Released reports for referral patients are not stored in TIU. A hardcopy of the report must be manually signed and kept on file. Users follow the same steps to release referral patient reports, however, an informational message will display. See Example 2 B for an illustration.

When the Electronic Signature Is Not Activated

If the electronic signature feature is *not* activated, the existing manual signature process asks the user if the report is to be released (see below). A ‘Yes or No’ response is required. If the response is yes, the report will be released, a paper copy is then printed, and the authorized user signs it by hand. Nothing is stored in TIU.

Example: Release Pathology Reports

```
Release Pathology Reports
Select ANATOMIC PATHOLOGY SECTION: SURGICAL PATHOLOGY
      SURGICAL PATHOLOGY (NSP)
Data entry for 2003 ? YES// <Enter> (YES)
Select Accession Number/Pt name: 72 for 2003
LABPATIENT, TEN ID: 000-00-0010
Specimen(s) : TOE
Release report? NO//<Enter>
```

Electronic Signature Is Activated

If the electronic signature feature *is* activated, the user is presented with the new electronic signature functionality. Three selections have been added as described in Table 3.

Example: Release Electronically Signed Pathology Reports

Release/Electronically Sign Pathology Reports	
Select one of the following:	
C	CPT Coding
E	Electronically Sign Reports
V	View SNOMED Codes

Shortcut Synonym	Selection	Description
C	CPT Coding.	CPT codes can be entered on released or unreleased Autopsy Protocol and SF 515 reports. (See Example 1 below for display of prompts.)
E	Electronically Sign Reports.	The authorized user selects this option to electronically sign out and release the report. After entering the anatomic pathology section and accession number/name, the authorized user is given the option to view the report using the FileMan Browser prior to releasing the report. Upon successful entry of the electronic signature code, the report is released, and a “snapshot” copy is stored in TIU. An alert is sent by default to the authorized physician, and to the primary care provider (if one is on file) for the accession. The electronic signer is then prompted to add names or mail groups to receive the alert. Additional names are entered in the following format: LAST,FIRST. Additional mail groups are entered as G.MAILGROUP. The text of an alert is displayed at the bottom of Example 3. (See Example 2 below for display of the prompts.)
V	View SNOMED Codes.	This option allows viewing and printing of SNOMED codes for an accession on a separate page. (See Example 3 below for display of the prompts.)

Example 1: Selection - CPT Coding.

```
Selection: CPT Coding

Select ANATOMIC PATHOLOGY SECTION: SURGICAL PATHOLOGY

    SURGICAL PATHOLOGY (NSP)

Data entry for 2003 ? YES// <Enter> (YES)

Select Accession Number/Pt name: 72 for 2003

LABPATIENT, SEVEN    000-00-0000    DOB: Mar 03, 1966
Collection Date: Jun 02, 2003
Acc #: NSP 03 72
    PCE ENC # 384;384;384;
Tissue Specimen(s):
    TOE
Test(s): H & E STAIN
    PARAFFIN BLOCK
    SURGICAL PATH REPORTING
    SURGICAL PATHOLOGY LOG-IN

Releasing Pathologist: LABPROVIDER1, ONE// <Enter> LPO  SR PATHOLOGIST
Would you like to see PCE CPT Information? No// YES

CPT: 88300          PATIENT NAME: LABPATIENT, SEVEN
VISIT: JUN 02, 2003@12:01    PROVIDER NARRATIVE: SURGICAL PATH, GROSS
QUANTITY: 1
CPT MODIFIER: 59
ENCOUNTER PROVIDER: LABPROVIDER1, TWO

Select CPT codes: 88307

LABPATIENT, SEVEN    000-00-0000    DOB: Mar 03, 1966
Collection Date: Jun 02, 2003
Acc #: NSP 03 72          Loc: 3E
    PCE ENC # 384;384;384;
Specimen:
Tissue Specimens:
    TOE
Test(s); H & E STAIN/ PARAFFIN BLOCK/ SURGICAL PATH REPORTING/ SURGICAL
PATHOLOGY LOG-IN/
    Selected CPT Codes

(1) 88307 TISSUE EXAM BY PATHOLOGIST

Is this correct ? Yes// <Enter> YES
    Sending PCE Workload
    Visit # 384
    Storing LMIP Workload
```

Example 2 A: Option E, Electronically Signed Reports

```

Selection: Electronically Sign Reports

Select ANATOMIC PATHOLOGY SECTION: SURGICAL PATHOLOGY

    SURGICAL PATHOLOGY (NSP)

Data entry for 2003 ? YES// <Enter> (YES)

Select Accession Number/Pt name: 72 for 2003

LABPATIENT, SEVEN      000-00-0007   DOB: Mar 03, 1966
Collection Date: Jun 02, 2003
Acc #: NSP 03 72
PCE ENC # 384;384;384;
Tissue Specimen(s):
    TOE
Test(s): H & E STAIN
    PARAFFIN BLOCK
    SURGICAL PATHOLOGY LOG-IN

View the report before signing? YES// NO

Enter your Current Signature Code: ***** SIGNATURE VERIFIED

*** Report is being processed for storage in TIU. One moment please. ***
..
*** Report storage in TIU is complete. ***

*** Report released. ***

Do you wish to send an alert? NO// <Enter>

```

The alert text is as follows:

```

Pathology report signed for SP 02 1 - LABPATIENT, SEVEN

```

Example 2 B: Option E, Electronically Signed Reports for Referral Patients

For referral patients, the released report is not stored in TIU since electronic signatures cannot be stored there. Rather, a hardcopy of the report must be hand-signed and kept on file. Follow the same steps to release referral patient reports as for other reports and an informational message displays upon release of the referral patient report. Here is an example of releasing a report for a referral patient and the informational message:

```
Selection: Electronically Sign Reports

Select ANATOMIC PATHOLOGY SECTION: SURGICAL PATHOLOGY

      SURGICAL PATHOLOGY (NSP)

Data entry for 2003 ? YES// <Enter> (YES)

Select Accession Number/Pt name: 62 for 2003

LABPATIENT1, ONE          DOB: May 05, 0000
Collection Date: May 19, 2003
Acc #: NSP 03 62
Tissue Specimen(s):
    THUMB
    TOE
Test(s): SURGICAL PATH REPORTING
        SURGICAL PATHOLOGY LOG-IN

View the report before signing? YES// NO

Enter your Current Signature Code: ***** SIGNATURE VERIFIED

    *** Report is being processed. One moment please. ***

    *** NOTE: This REFERRAL PATIENT report will not be stored in TIU, and
    therefore, does not have an electronic signature.
           A hardcopy signature will be required for this report.

                *** Report released. ***

Do you wish to send an alert? NO// <Enter>
```

Example 3: Option V, View SNOMED Coding

```
Selection: View SNOMED CODING

Select ANATOMIC PATHOLOGY SECTION: CYTOPATHOLOGY
      CYTOPATHOLOGY (NCY)
Data entry for 2003 ? YES// <Enter> (YES)
Select Accession Number/Pt name: 1 for 2003
LABPATIENT1, TWO      000-00-0012   DOB: May 02, 1952
Collection Date: Jan 06, 2003
Acc #: NCY 03 1
      Tissue Specimen(s):
      PAP
      Test(s): PAP SMEAR
DEVICE: HOME// UCX/TELNET
CYTOPATHOLOGY  SNOMED CODE LISTING  Acc: NCY 03 1  Pg: 1
Patient: LABPATIENT1, THREE      Physician: LABPROVIDER, THREE
ID: 000-00-0013   Sex: F      DOB: May 02, 1952  Age: 51
-----
Tissue Specimen(s):
      PAP

T-42500: ABDOMINAL AORTA
      M-41770: ABSCESS, DRAINING
T-46400: CELIAC ARTERY
      M-69610: CELL MITOTIC ACTIVITY, INCREASED
              (End of Report)
```

Supplementary report release, anat path [LRAPRS] option

Another enhancement of the release process for supplementary reports is to prompt for an electronic signature rather than prompting for a YES/NO response to the question “Release Report?”. The *Supplementary report release, anat path* option now includes the release of autopsy supplementary reports. Be aware that supplementary reports that have been electronically signed will *not* include a signature and date/time stamp in the report text.

The *Supplementary report release, anat path* option also provides a direct link to the *Verify/release reports, anat path [LRAPR] option*. The user is conveniently jumped to the verify/release option for the whole report, provided the accession passes certain edits, as listed below. This jump occurs at the “Release main report?” prompt, as seen in Example 2:

Edits the accession must pass are as follows:

- All supplementary reports for the accession must be released.
- The pathologist/cytotechnologist must be entered on the accession.
- Generally, the user signing out the supplementary report is the same user as the pathologist/cytotechnologist entered on the main report. If different, a warning message displays, but will not prevent the user from proceeding to the *Verify/release reports, anat path option* in order to sign off on the whole report.

Example 1: Release Supplementary Pathology Report

```

Release Supplementary Pathology Reports

Select ANATOMIC PATHOLOGY SECTION: SURGICAL PATHOLOGY
Data entry for 2003 ? YES// <Enter> (YES)

Select Accession Number/Pt name: 72 for 2003
LABPATIENT1, FOUR      000-00-0014
Specimen(s) :
TOE

Select SUPPLEMENTARY REPORT DATE: JUN 29, 2003// <ENTER> JUN 29, 2003

Enter your Current Signature Code: ***** SIGNATURE VERIFIED...Released

```

One of three possible responses will display when a released supplementary report is selected:

1. No supplementary reports exist for the accession, or
2. All supplementary reports for the accession have been released, or
3. Will default to the most recently entered supplementary report for the accession.

Example: If an attempt is made to release a report that has an existing unreleased supplementary report, the attempt is aborted and the following message is displayed to the user:

```

Supplementary report JUN 29, 2003 has not been released. Cannot release.

```

Example 2: Release Supplementary Pathology Reports with direct link to *Verify/release reports* option. This example shows the direct link path and displays the warning message the sign-out user receives if he or she is not the same user as the pathologist/cytotechnologist entered on the accession.

```

Release Supplementary Pathology Reports

Select ANATOMIC PATHOLOGY SECTION: SURGICAL PATHOLOGY

Data entry for 2003 ? YES// <Enter> (YES)
Select Accession Number/Pt name: 96 for 2003
LABPATIENT1, FIVE ID: 000-00-0015
Specimen(s) :
TOE

Select SUPPLEMENTARY REPORT DATE: AUG 20, 2003// <Enter> AUG 20, 2003

Enter your Current Signature Code: ***** SIGNATURE VERIFIED...Released
Release main report? YES//YES

Supplemental release User ID does not match the
Pathologist/Cytotechnologist User ID on the main report.
Do you want to proceed with release of the main report?

CONTINUE ? YES// YES

Release/Electronically Sign Pathology Reports

Select one of the following:

C CPT Coding
E Electronically Sign Reports
V View SNOMED Codes

Selection: Electronically Sign Reports

Select ANATOMIC PATHOLOGY SECTION: SURGICAL PATHOLOGY

SURGICAL PATHOLOGY (NSP)

Data entry for 2003 ? YES// <Enter> (YES)

Select Accession Number/Pt name: 96 for 2003

LABPATIENT1, FIVE 000-00-7777 DOB: May 05, 1965
Collection Date: Aug 19, 2003
Acc #: NSP 03 96
Tissue Specimen(s) :
TOE
Test(s) : SURGICAL PATH REPORTING
SURGICAL PATHOLOGY LOG-IN

View the report before signing? YES// NO

Enter your Current Signature Code: SIGNATURE VERIFIED

*** Report is being processed for storage in TIU. One moment please. ***

*** Report storage in TIU is complete. ***
*** Report released. ***

Do you wish to send an alert? NO//
    
```

List of unverified pathology reports [LRAPV] option

This option is modified to add a new selection to the List of Unverified Pathology Report. This new selection, “*List of SURGICAL PATHOLOGY Reports Missing SNOMED Codes,*” displays missing SNOMED codes for a specific date range for Autopsy Protocol, SF 515, and supplementary reports. The date, accession number, patient name, and SSN is listed for each unverified report, within the specified date range, and can be viewed on-line or printed.

Example: The following example shows the new selection and the resulting listing.

```

1) List of Unverified SURGICAL PATHOLOGY Reports
2) List of Unverified SURGICAL PATHOLOGY Supplementary Reports
3) List of SURGICAL PATHOLOGY Reports Missing SNOMED Codes

Select 1,2 or 3: 3
Start with Date TODAY// T-20 (JUN 12, 2003)
Go to Date TODAY// Jul 02, 2003

DEVICE: HOME// UCX/TELNET

Jul 02, 2003 09:34 REGION 7 ISC, TX (KRN)          Pg: 1
SURGICAL PATHOLOGY (NSP) REPORTS MISSING SNOMED CODING
BY DATE SPECIMEN TAKEN FROM Jun 12, 2003 TO Jul 02, 2003
DATE   Accession number Patient          SSN
-----
Jun 12, 2003  NSP 03 74 LABPATIENT1, SIX    000-00-0016
Jun 18, 2003  NSP 03 79 LABPATIENT, SEVEN  000-00-0007

```

Clinician options, anat path ... [LRAPMD] Menu

The Clinician options, anat path ... menu contains sub-options, listed below. To the left is the shortcut synonym you can enter to select the option. The sub-options that have been modified are in bold.

- DS** *Display surg path reports for a patient*
- DC** *Display cytopath reports for a patient*
- DE** *Display EM reports for a patient*
- LT *Edit/print/display pr-eselected lab tests ..*
- PS *Print surgical pathology report for a patient*
- PC *Print cytopathology report for a patient*
- PE *Print electron microscopy report for a patient*
- CS *Cum path data summaries*
- AR *Autopsy protocol/supplementary report*

Display surg path reports for a patient [LRAPSPCUM]

The *Display surg path reports for a patient* option is used to display surgical pathology reports on the screen for a selected patient if the report has been verified. This option is modified to include SNOMED codes on the report display for only those users possessing the LRLAB security key. Non-laboratory personnel, or any user without the LRLAB key, will not see the SNOMED codes on the report display.

Display cytopath reports for a patient [LRAPCYCUM]

The *Display cytopath reports for a patient* option is used to display cytopathology reports on the screen for a selected patient if the report has been verified. The option is modified to include SNOMED codes on the report display for only those users possessing the LRLAB security key. Non-laboratory personnel, or any user without the LRLAB key, will not see the SNOMED codes on the report display.

Display EM path reports for a patient [LRAPEMCUM]

The *Display surg path reports for a patient* option is used to display electron microscopy reports on the screen for a selected patient if the report has been verified. The option is modified to include SNOMED codes on the report display for only those users possessing the LRLAB security key. Non-laboratory personnel, or any user without the LRLAB key, will not see the SNOMED codes on the report display.

Deleted Anatomic Pathology Options

Electronic Signature Patch LR*5.2*259 release creates changes to some options on the Anatomic Pathology Menu [LRAP]. Two options are automatically deleted during the installation of Patch LR*5.2*259 as follows:

1. *Modify anat path gross/micro/dx/frozen section* [LRAPM] option
This option is deleted to prevent editing of gross and microscopic descriptions, as well as diagnosis and frozen fields on released SF 515 and supplementary reports.
2. *Modify Move anatomic path accession* [LRAPMV] option
This option is deleted to protect the integrity of data stored in the LAB DATA (#63) and TIU DOCUMENT (#8925) files. With the implementation of the electronic signature functionality, the report data are stored in two places: 1) in fields in the Lab global and 2) as a whole document in the TIU Document global. Once a report is stored in TIU it cannot be updated. Moving an accession would update that accession in the Lab global but not the report in TIU, and the two globals would be out of sync. Deleting this option prevents this out-of-sync condition from occurring.

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Glossary

The following glossary of terms is related to this software release:

Glossary of Terms	Description
Accession Area:	A functional area or department in the laboratory where specific tests are performed. The accession area defines the departmental designation contained in each accession.
Accession Number:	A unique alpha-numeric (combination of letters and numbers) assigned to an individual patient specimen when it is received in the laboratory. The accession is assigned by the computer and contains the laboratory departmental designation, the date, and an accession number. This accession serves as identification of the specimen as it is processed through the laboratory. (Example: HE 09121). It also associates billable items with a specific billable event such as an outpatient visit or an inpatient stay.
ADPAC:	Automated Data Processing Application Coordinator
Alert:	Brief on-line notice issued to users as they complete a cycle through the menu system. Alerts are designed to provide interactive notification of pending computing activities, such as the need to reorder supplies or review a patient's clinical test results. Along with the alert message is an indication that the View Alerts common option should be chosen to take further action.
AP:	Anatomic Pathology
Anatomic Pathology Reports:	Anatomic Pathology reports (also called AP reports) include reports for all sections: Surgical Pathology, Cytology (Cytopathology), Electron Microscopy, and Autopsy Pathology sections.
API:	Application Programming Interface
Audit Trail:	A chronological record of computer activity automatically maintained to trace the use of the computer.

Glossary of Terms	Description
Authorized Signer:	A user who has been granted proper authority to sign out and release anatomic pathology reports. In general, authorized signers are pathologists and cytotechnologists (i.e., cytotechnologists for negative GYN only).
Authorized User:	A user who has been granted access to a menu option or options, and/or the user is properly defined in the system to perform a function.
Computerized Patient Record System:	Computerized Patient Record System (CPRS) is a VistA software application that facilitates the entry, review, and modification of patient-related information, as well as a means of ordering services such as lab tests.
CPRS:	Computerized Patient Record System
CPT:	Current Procedural Terminology
Current Procedural Terminology:	Current Procedural Terminology (CPT) is a uniform system of codes (such as identifiers) associated with specific procedures (such as tests).
DBIA:	Data Base Integration Agreement
DSM:	Digital Standard Mumps
Electronic Signature:	A code, entered by a user, which represents his or her legally binding signature.
Encryption:	Scrambling data or messages with a cipher or code so that they are unreadable without a secret key. In some cases encryption algorithms are one directional; they only encode and the resulting data cannot be unscrambled (e.g., access/verify codes).
Free Text:	The use of any combination of numbers, letters, and symbols when entering data.
Global:	In the MUMPS language, a global is a tree-structured data file stored in the common database on the disk
HSD&D:	Health Systems Design & Development
ICD-9:	International Classification of Disease, 9 th edition
ICD-10	International Classification of Disease, 10 th edition
NT:	New Technology
OI:	Office of Information

Glossary of Terms	Description
Sections:	Anatomic Pathology (AP) work is divided into four areas or sections: Surgical Pathology, Cytology (Cytopathology), Electron Microscopy, and Autopsy Pathology.
Security Key:	Level of security that can be applied to menu options. Options can be locked with a security key. Only users given the appropriate key can use a locked option. If the user does not have the key, then even if the locked option is on the user's menu, the user cannot to use it. Options that provide specialized or supervisory access are usually locked with a security key.
SF 515:	Standard Form 515. Anatomic Pathology report format design for the Cytology, Electron Microscopy, and Surgical Pathology sections.
SNOMED:	Systematized Nomenclature of Medicine
SNOMED CT:	Systemized Nomenclature of Medicine Clinical Terms
Supplementary Report:	An electronically signed report that adds additional data to the original report. The additions do not change any data that had been previously verified. This supplement becomes part of the whole report.
TIU:	Text Integration Utility
VA:	Department of Veterans Affairs
VA FileMan:	A set of programs used to enter, maintain, access, and manipulate a (also called database management system consisting of files. A package of on-line VA FileMan) computer routines written in the MUMPS language which can be used as a stand-alone database system or as a set of application utilities. In either form, such routines can be used to define, enter, edit, and retrieve information from a set of computer-stored files.

Glossary of Terms	Description
VAMC:	Department of Veterans Affairs Medical Center
VC:	Veterans Center
VDL:	Vista Documentation Library
VDSI:	Vista Data Systems and Integration
VHA:	Veterans Health Administration
VistA:	Veterans Health Information Systems and Technology Architecture
VistA Laboratory:	Entire Laboratory application consisting of the following modules: Anatomic Pathology, Microbiology, and Routine Clinical Lab

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